



STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

MISSISSIPPI §1915(C) WAIVER CA-PRTF

APPROVAL DATE:
October 1, 2007

IMPLEMENTATION DATE:
November 1, 2007

AMENDMENT DATE:
July 1, 2010



Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver’s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Mississippi** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Psychiatric Residential Treatment Facilities Application

C. Waiver Number: MS.01

D. Amendment Number: MS.01.R01.03

E. Proposed Effective Date: (mm/dd/yy)

07/01/10

Approved Effective Date: 07/01/10

Approved Effective Date of Waiver being Amended: 11/01/07

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
 Increase the unduplicated count for Yr 3, Yr 4 and Yr 5 of the waiver demonstration.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input type="checkbox"/> Appendix B – Participant Access and Eligibility	
<input type="checkbox"/> Appendix C – Participant Services	
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Mississippi requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Psychiatric Residential Treatment Facilities Application

C. Type of Request: amendment [PRTF Demonstration Grant]

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

- 3 years 5 years

Waiver Number: MS.01.R01.03

Draft ID: MS.01.01.05

D. Type of Waiver (select only one):

Regular Waiver

E.

Proposed Effective Date of Waiver being Amended: 11/01/07

Approved Effective Date of Waiver being Amended: 11/01/07

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

- Hospital
Select applicable level of care
- Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

[Demonstration Only] Psychiatric Residential Treatment Facility (PRTF)

If applicable, specify whether the State additionally limits the waiver to subcategories of the PRTF level of care:
No subcategories

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods. The Mississippi SED waiver, Mississippi Youth Programs Around the Clock (MYPAC) will offer a variety of services to participants and their families who are either deinstitutionalized or diverted from the PRTF admission. Participants eligible for the waiver are between the age of 0 and 22. It is expected the majority of referrals will be between the ages of 8 and 18. Participants may only be admitted prior to their 21st birthday. If they are already enrolled in the waiver prior to their 21st birthday, they may remain in the waiver until they complete treatment or turn 22.

Both functional and financial criteria must be met to be eligible for the waiver. An applicant must have a diagnosis of mental disorder under the DSM-IV criteria and be determined by a Qualified Mental Health Professional to have a serious emotional disturbance. Once functional criteria have been met, the MS Division of Medicaid Eligibility offices will determine a participant's financial eligibility for the waiver.

The waiver is managed by MS Division of Medicaid, Bureau of Mental Health Programs. HCBS SED Waiver services will be provided by Mental Health Providers. The Quality Improvement Organization (QIO), a sub contractor, will determine clinical eligibility and appropriateness of the proposed delivery of services to waiver participants. The QIO reviews and prior authorizes the waiver services in each Individualized Service Plan (ISP) as MS refers to the plan of care (POC) document. The Director for the Special Mental Health Initiatives Division, which oversees administration of the waiver, will receive a daily report of pending, approved, or denied ISP/POC. The QIO will ensure ongoing Quality Assurance and Performance Improvement reviews in compliance with CMS standards.

Each provider must meet both State certification requirements for case management and be accredited as a child serving agency. The waiver provider will also conduct internal Quality Assurance activities to regularly review each waiver participant's ISP/POC and outcomes. The QIO will employ assessment methods as described in Appendix A 6 to meet performance measures specific to the waiver.

The waiver will provide for transition for those who age out of the program and for those who are in the program at the end of the 5 year grant period, should a regular 1915 (c) not be an option. Services will be identified by the participant/family, natural supports and the Community Mental Health Centers through the Wraparound process. The Primary Services Coordinator (PSC) who will be involved in the wraparound services will link and access those identified services to the participant/family before the participant ages out of the MYPAC waiver in order to achieve a successful transition.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

- Not Applicable**
- No**
- Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

- No**
- Yes**

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed

in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
As part of the implementation of the of the C-TAC grant MS Families As Allies, Inc. held nine focus groups across the state with parents of children with serious mental health needs. Parents provided feedback and discussion regarding their children's needs to stay in their home/communities. Several of these needs included training for school staff on mental health needs, crisis intervention, special education procedures, use of Positive Behavioral

Intervention Support (PBIS), and family sensitivity. The parents also identified the following gaps in their communities: lack of affordable after-school programs, lack of support groups for youth, lack of well-staffed community resource centers, lack of specialized child care, lack of transportation assistance, and the need for more church involvement.

During the development of the grant application, families provided input via the ISCC in the inclusion of parents in the waiver application process. As a result, Division of Medicaid added part-time positions for family mentors or parent-to-parent partners, referred to as Family Support Specialists, who will work directly with the families seeking and receiving services. Monitoring and supervision of this staff will be provided by MSFAA. Parent partners will provide feedback and insight to the Division of Medicaid in the administration of the program.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	<input type="text" value="Plotner"/>
First Name:	<input type="text" value="Kristi"/>
Title:	<input type="text" value="Bureau Director (Mental Health Programs)"/>
Agency:	<input type="text" value="Mississippi Division of Medicaid"/>
Address:	<input type="text" value="550 High Street"/>
Address 2:	<input type="text" value="Sillers Building, Suite 1000"/>
City:	<input type="text" value="Jackson"/>
State:	Mississippi
Zip:	<input type="text" value="39201"/>
Phone:	<input type="text" value="(601) 359-6698"/> Ext: <input type="text"/> <input type="checkbox"/> TTY
Fax:	<input type="text" value="(601) 359-6294"/>
E-mail:	<input type="text" value="kristi.plotner@medicaid.ms.gov"/>

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	<input type="text"/>
First Name:	<input type="text"/>
Title:	<input type="text"/>
Agency:	<input type="text"/>
Address:	<input type="text"/>
Address 2:	<input type="text"/>
City:	<input type="text"/>
State:	Mississippi
Zip:	<input type="text"/>
Phone:	<input type="text"/> Ext: <input type="text"/> <input type="checkbox"/> TTY
Fax:	<input type="text"/>
E-mail:	<input type="text"/>

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	<input type="text" value="Phyllis Williams"/>
	State Medicaid Director or Designee
Submission Date:	<input type="text" value="Aug 20, 2010"/>

Last Name:	<input type="text" value="Williams"/>
First Name:	<input type="text" value="Phyllis"/>
Title:	<input type="text" value="Deputy Administrator, Health Services"/>
Agency:	

Address:
Address 2:
City:
State: **Mississippi**
Zip:
Phone:
Fax:
E-mail:

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not Applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

Health Services/ Bureau of Mental Health Programs

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b*).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Quality Improvement Organization (QIO) is responsible for conducting pre-certification and concurrent review determinations for Medicaid-covered services, including Psychiatric Residential Treatment Facility (PRTF) services and services under the 1915 (c) waiver for youth with Serious Emotional Disturbance. The QIO will be responsible for administrative functions on behalf of the Medicaid agency. The QIO will not provide direct services and will not perform assessments or evaluation. Therefore, there is no identified conflict of interest.

The QIO will provide informational workshops and educational programs for providers. Educational programs are available to providers through one-on-one meetings, telephone conferences, web casts and workshops.

The QIO provides a reconsideration process for any beneficiary, facility, or physician who receives a Utilization Review Denial Notice the opportunity to request and receive a reconsideration of a determination.

The QIO advises any involved party (beneficiaries, representatives, providers, and physicians) in writing, of all initial denial determinations. All parties are notified of the right to request reconsideration and the timeframes for submitting a request. Any party who receives a denial notice and disagrees with the determination may request a reconsideration of the determination.

The Parham Group, Nonprofit Advisors is a consulting firm specializing in helping public and private nonprofit organizations cultivate leadership, promote credibility, and reach maximum effectiveness. The Parham Group will perform the services such as assisting and facilitating the development of the required implementation plan. The Parham Group will also assist and facilitate the development of the Request for Proposals for the waiver providers, an RFP evaluation or rating instrument, and assist with the waiver provider selection process. The Parham Group will coordinate and facilitate the identification of professional service needs (such as evaluation services and training/technical assistance services), appropriate and qualified providers, and the development of professional service contracts. The Parham Group will provide additional administrative, project integrity, and advisory services.

Mississippi Families As Allies for Children's Mental Health will provide and train family support specialist that will encourage and counsel family members. MSFAA will also provide the training and supervision of the Family Support Specialist on their representing the interest of the participating youth and his/her family. This agency will develop, gather and report on family feedback information for the waiver. MSFAA will provide respite services and train community respite providers. MSFAA will provide staff to assist with the evaluation aspects of the waiver.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
 - Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

The Community Mental Health Centers will be responsible for performing the functional assessments required for the National Evaluation. These functional assessments will also be used to develop the ISP/POC and will be used by the QIO in the redetermination process for the PRTF Level of Care. The State will pay for the cost of these services through an existing provider agreement with the local Community Mental Health Centers which provide services under the rehabilitation option of the MS State Plan and the MS Code 43-13-117.

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Division of Medicaid.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Division of Medicaid will establish a work plan and a schedule of deliverables for each contracted entity. Once all contracts have been executed and the waiver begins operation, deliverables will be due at least quarterly through year 1 and year 2 of the grant and then due every 6 months. Division of Medicaid will have authority to request ad hoc reporting with a 30 day response time.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The Bureau of Mental Health within the Medicaid agency retains 100% oversight over the waiver.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Monthly reports are generated from the MMIS system to determine funds availability for the operation of the waiver. The monthly reports are matched to the quarterly reports to ensure accuracy.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Not applicable since DOM maintains total authority.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input checked="" type="radio"/> Mental Illness					
	<input checked="" type="checkbox"/>	Mental Illness	22		
	<input checked="" type="checkbox"/>	Serious Emotional Disturbance	0	21	

b. Additional Criteria. The State further specifies its target group(s) as follows:

The target population for this demonstration waiver will be youth:

- 1) under age 21,
- 2)with serious emotional/behavioral/mental disturbances (youth who currently have or at any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria for SED(Serious Emotional Disorder) specified within DSM-IV),
- 3)who are at immediate risk of or who have been institutionalized, 4) who need specialized services and supports from multiple agencies,
- 5)who meet the State’s Medicaid level of care requirement for admission to a PRTF,
- 6) who meet the Medicaid financial eligibility requirements as described in the waiver application and whose families choose community-based services in lieu of PRTF.

This demonstration waiver will be used both to divert youth from admission to a PRTF and to successfully transition youth from PRTFs into the community, thereby shortening the length of stay and reducing the risk of recidivism. As is currently being done for PRTF's, if the individual is enrolled prior to their 21st birthday they will be maintained in the waiver until they complete treatment or turn 22 whichever comes first.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

The participants will have a plan of care (MS refers to as the individualized service plan- ISP) developed within the first fourteen (14) days of entering the waiver and reviewed every 30 days. The Wraparound services will be provided to the participant and there will be a review of services as long as the participant is in the CA-PRTF waiver. Throughout this process the participant’s family needs, goals, objectives, resources, and strengths are

identified. Preference to the goals that are included in the ISP/POC will be given to those the family/guardian/parents and participant identify as the most pertinent or pressing. As the participant ages out of the MYPAC waiver, services will be identified by the participant/family, natural supports and the Community Mental Health Centers through the Wraparound process. The Primary Services Coordinator (PSC) who will be involved in the wraparound services will link and access those identified services to the participant/family before the participant ages out of the MYPAC waiver in order to achieve a successful transition. Community Mental Health Centers are prohibited from denying mental health services to participants because of an inability to pay fee.

If the participant meets the more stringent criteria for adults with Severe and Persistent Mental Illness (SPMI) they are offered the full array of community-base mental health services necessary to successfully manage their illness, support their recovery process, and live meaningful lives in their community.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (*select one*):

- The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

- Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- The following percentage that is less than 100% of the institutional average:

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):
 - The participant is referred to another waiver that can accommodate the individual's needs.
 - Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to

CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	120
Year 2	350
Year 3	500
Year 4	550
Year 5	600

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- The State does not limit the number of participants that it serves at any point in time during a waiver year.
- The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	120
Year 2	225
Year 3	300
Year 4	350
Year 5	420

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals selected for entrance into the waiver must meet the established waiver criteria, as specified in Appendix B-1 (b).

As youth are identified and recommended through local portals such as the MAP teams, the Waiver Division Director and Assessment Team perform a review. A family member representative on the Team contacts the youth's parent or guardian and initiates a conversation regarding the demonstration project and possible inclusion of the youth. An initial screening will be performed (coordinated by the Waiver Director and family representative) as to basic eligibility, and such things as family/guardian support, guardian/caregiver interest, safety of current living arrangements, and medical condition that prevents or severely limits inclusion in home and community-based interventions. A complete assessment, including a psychological evaluation and an IQ assessment, will also be performed for program compatibility and treatment identification. Those youth and their parent/guardian who meet the eligibility and other requirements, and who choose to participate in the demonstration project will be referred to a Primary Service Coordinator(PSC) for certification as PRTF eligible.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. State Classification. The State is a (*select one*):

- §1634 State**
- SSI Criteria State**
- 209(b) State**

2. Miller Trust State.

Indicate whether the State is a Miller Trust State (*select one*):

- No**
- Yes**

- b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act**
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional State supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)**
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)**
 Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
 Medically needy in 209(b) States (42 CFR §435.330)
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
 Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

1902(a)(10)(A)(i)(1) - IVE Foster Care & Adoption Assistance children

1902(a)(10)(A)(ii)(1)- State Foster Care (CWS) children

1902(a)(10)(A)(ii)(VIII)- State Adoption Assistance Children

1902(a)(10)(A)(ii)(XVII)- Protected Foster Care adolescents

1902(a)(10)(A)(i)(VI)- Children Under Age 6 Under 133% of Poverty

1902(a)(10)(A)(i)(VII)- Children Under age 19 Under 100% of Poverty

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**
 Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217**
 Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
 A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.**

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
 Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
 Medically needy without spend down in 209(b) States (42 CFR §435.330)
 Aged and disabled individuals who have income at:

Select one:

- 100% of FPL**
 % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
 Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

- The following standard included under the State plan**

Select one:

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of the FBR, which is less than 300%**

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller trust.

- Other**

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable**
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

- Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges

- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:**

Specify formula:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller trust

Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- Allowance is the same**
- Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.**
- The State does not establish reasonable limits.**
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The State requires (select one):

- The provision of waiver services at least monthly**
- Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

Specify the entity:

- Other**
Specify:

The Level of Care evaluations and reevaluations will be provided by a Qualified Mental Health Professional who is a Medicaid provider. The qualifications for a Qualified Mental Health Provider are: Physician (MD or DO), Psychiatric Mental Health Nurse Practitioner, licensed psychologist (Ph.D. clinical). The providers of the Level of Care evaluations will NOT be the waiver providers.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Mississippi Division of Medicaid will require that individuals performing the initial evaluations be Physician's (MD or DO) with a specialty in psychiatry or a clinical psychologist. They must be Medicaid providers; licensure is checked at time of enrollment and the provider number expires with the licensure expiration. Any relationship between the psychiatrist or psychologist and the PRTF or waiver to which the youth is being admitted is strictly prohibited. The Level of Care evaluation must be an independent process for evaluation of the need for the PRTF level of care.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The initial level of care determination is made based upon the clinical judgment of either a MS-licensed, practicing, independent child psychiatrist or a licensed, practicing, independent child psychologist. Currently no formal instrument or tool is utilized for level of care evaluation. Upon the initial determination of need by the psychiatrist or psychologist, HSM confirms or denies that applicant as meeting the requirements for admittance to a PRTF using the following criteria:

The child has a diagnosable psychiatric disorder.

The child has a full scale IQ of 60 or above.

The child's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.

The referring psychiatrist/psychologist advises that residential treatment is needed.

At least one of the following:

- The child has failed to respond to less restrictive treatment.
- Adequate less restrictive options have not been available in the child's community.
- The child is currently in an acute care facility whose professional staff advise that residential treatment is needed.

The admission has been certified by the QIO as medically and psychologically necessary.

Upon confirmation by HSM, the applicant is eligible for admittance to the waiver.

At the time of re-evaluation of the participant, the CANS functional assessment instrument will be utilized by the QIO to evaluate and determine level of functioning and continuation in the waiver. The assessment and reassessment, although using different instruments, will result in the same outcome.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

MS Division of Medicaid will have two areas of eligibility a participant must meet to be enrolled into the waiver program. One is Clinical (also called Functional) and Financial. A qualified mental health professional such as a Physician (MD or DO) with a specialty in psychiatry or a clinical psychologist will be responsible for evaluating clinical eligibility. Key features of clinical eligibility include:

- Age – Applicants must be between the age of 0 and through the age of 21 years old,
- Diagnosis – an Axis I mental health diagnosis must be present.
- SED/MI Criteria – All participants on the waiver age 0-17 must be identified as SED; participants age 18-21 must be identified as SPMI.
- QIO criterion – A participant must be determined as likely to need a PRTF level of care in the absence of waiver services.

Annual Reevaluation – The need for HCBS SED Waiver services is re-evaluated at a minimum on an annual basis but also any time the family feels it is appropriate, as needs change, and /or as goals are completed. The format for re-evaluating the level of care will be guided by the clinical impressions of the QMHP (Qualified Mental Health Professional), the progress towards goals and objectives, and the CANS-MH which is completed every 6 months.

Notice of Action – When a participant is found clinically eligible or ineligible during the initial evaluation or the annual re-evaluation their family will receive a Notice of Action advising them of the status of clinical eligibility and their appeal rights, including the right to a fair hearing.

All clinical eligibility documentation including the initial evaluation, the annual re – evaluation and the notice of action are to be maintained in the participant’s clinical record.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months**
- Every six months**
- Every twelve months**
- Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- The qualifications are different.**

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Required to submit 7 days prior to last certified day or the certification days will expire. In addition the Division of Medicaid will receive a monthly census report which will outline the expiration date for the current period. The waiver providers and assessors will be contacted 30 days prior to the expiration date and notified the assessments are due in order that a LOC determination may be made prior to the expiration date.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Division assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years. In addition to the waiver providers being required to maintain records, Health Systems of Mississippi, the QIO receives and maintains copies of all documents required for initial and concurrent review.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

- a. Methods for Discovery: Level of Care Assurance/Sub-assurances**
 - i. Sub-Assurances:**

- a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All (100%) of waiver admissions will have a LOC determination made prior to enrollment. The independent evaluation recommending the need for PRTF LOC will be submitted by the waiver provider to the UMQIO. The UMQIO will assess medical necessity, quality of services and determine the appropriateness of the setting and the number of days reasonably required to treat the participant’s condition.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: UM-QIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-assurance: *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All enrolled participants are re-evaluated annually. Upon entry, they are certified for 364 days. DOM will notify providers of the participants whose certification expires the following month, so the re-evaluation can be scheduled. If the provider determines continued enrollment in the waiver is required, they must submit a request for certification to the UM-QIO.

Data Source (Select one):

Other

If 'Other' is selected, specify:

The participants are "locked-in" to the waiver for 364 days. Reports will be run from the MMIS using DSS software to identify any lock-in date that is more than 364 days.

Responsible Party for data	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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collection/generation (check each that applies):		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The UMQIO, independent of the provider, determines the LOC based on the independent assessments submitted and the guidelines specified in the waiver.

Data Source (Select one):

Trends, remediation actions proposed / taken

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: UM-QIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For the Level of Care assurance, the DOM contracted with the UMQIO to independently assess the Level of Care and remove that function from the primary support coordinators. The PSC will recommend the need for waiver enrollment or continued stay, however the UMQIO will make that determination. The State monitors the contract with the UMQIO based on deliverables submitted. The State has designed this method to prevent problems and issues within the waiver related to LOC determinations before they happen.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Should the UMQIO not review requests within the timeframes specified in the contract, they will be required to submit a Corrective Action Plan to the DOM. In addition, they may be assessed penalties based on non-performance.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- Once the consumer is determined clinically eligible for waiver services, the consumer and family receives:
 - A copy of the forms used to document freedom of choice and fair hearing rights;
 - A description of the waiver provider's procedure for informing eligible consumers and/or their family of the feasible alternatives available under the waiver;
 - A description of DOM's procedures for allowing consumers to choose either institutional or home and community-based services;
 - A description of how the consumer and/or family member is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

Family Support Specialists (FSS), who will be contracted with DOM, will ensure consumers and/or family members fully understand their options and rights as they enter the waiver program and continually throughout the consumer's tenure. The FSS, who is required to be a current or former family member and to have successfully completed "family support" training provided by DOM, will also act as an advocate for the consumer. In addition, the waiver provider is responsible for providing and/or explaining the freedom of choice form and information to the consumer/family.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The waiver provider will keep the original on file in the youths comprehensive record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

DOM has access to the Language Line Service that provides access in moments to interpreters. As many as 140 languages are converted into English seven days a week, 24 hours a day. The Language Line service makes a dramatic difference when dealing with non-English speakers face-to-face or over the phone. The Language Line services has been an efficient way to overcome the language barrier.

Medicaid policy requires all Medicaid providers to have policies in place which will address the needs of individuals with limited English proficiency.

In addition, educational materials developed for this project will be available in other languages.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Case Management		
Statutory Service	Respite		
Other Service	Functional Assessment		
Other Service	Wraparound		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Case management is defined as services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case management providers under the MS HCBS SED waiver will be Primary Service Coordinators (PSC). The PSC will be responsible for the ongoing monitoring of the provision of services included in the participant's service plan and/or participant health and welfare. Case management may be provided to an individual who is currently in a PRTF in order to facilitate their transition to the community through the use of case management by the PSC. However, the PSC may not bill the DOM for case management until the individual is enrolled in the waiver.

The individual who will provide case management as a PSC must meet the minimum standards as established by the MS Department of Mental Health (DMH) and the agency must be certified by the DMH as a case

management provider. MS will enroll agency providers. The case load size per individual will be 12-15 as recommended by the Child Welfare League of America. Each participant in the waiver will be assigned a single person as their PSC.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1 services per month.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case management

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case management

Provider Qualifications

License (specify):

Certificate (specify):

Programs providing case management must be certified as case management providers by the Department of Mental Health after a thorough program review indicates the program has met all case management standards for mental health providers as specified in the Minimum Standards.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

ACS, the DOM fiscal agent will require certification for initial application. The DOM Mental Health Programs Bureau will also review all initial applications and will verify with the Dept. of Mental Health.

Frequency of Verification:

This verification will occur at a minimum of annually. If an end date is on the certification, a provider close date will be entered on the MMIS provider file, so that unless the provider submits proof the certification has been updated, the provider number will be closed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Respite is defined as services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. MS will provide in-home respite as a service defined under wraparound. Respite as a direct service will be out-of-home Respite in either a PRTF or an acute psychiatric unit of a hospital. FFP will be claimed for room and board when respite is provided in these locations, as allowed by CMS.

Respite in a PRTF or acute psychiatric unit of a hospital will be limited to 29 consecutive days per episode and 45 days per State fiscal year. During the 29 consecutive days allowed for respite, the wraparound provider and the State Division of Medicaid (DOM) will share the cost of the care.

For PRTF respite, the provider of wraparound services will pay for the first 9 days of PRTF respite. The next 10 consecutive days will be paid as respite by DOM. The final 10 consecutive days will be paid by the wraparound provider.

For Respite in an Acute Psychiatric Unit of a hospital, the wraparound provider will pay for days 1-3. DOM will pay the cost for days 4-14 at a per diem rate. The wraparound provider will pay for days 15 – 29.

The 29 consecutive days and 45 days per fiscal year limit may be met with a combination of PRTF Respite and Acute Psych Respite.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 29 days. However, the cost will be shared as specified above.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite

Provider Qualifications

License (specify):

For PRTF respite, the provider must be licensed as a PRTF. For respite in an acute psychiatric unit, the hospital must be licensed.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid will verify upon enrollment into the program.

Frequency of Verification:

Will be verified when they are enrolled and when original license expires and also periodically through on-site compliance reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Functional Assessment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Functional Assessment is a process by which waiver participants are assessed for their current level of functioning by use of identified instruments. As part of the National Evaluation required for this demonstration, MS will use the CANS, the YSS, the YSS-F, the MCSQ, the EQ-R.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Assessments will be done subsequent to enrollment, at 6 month intervals and at the time of discharge from the waiver.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Centers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Functional Assessment

Provider Category:

Agency

Provider Type:

Community Mental Health Centers

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Department of Mental Health as meeting all the requirements listed in the Minimum Standards.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Medicaid

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Wraparound

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

The MS Division of Medicaid waiver providers will provide Wraparound services to the participants in the waiver program. Wraparound efforts occur in the community, where services are individualized to meet children's and families' needs. Parents are included in every stage of the process and the approach must be culturally sensitive to the unique racial, ethnic, geographical and social makeup of children and their family. The process of wraparound is designed and implemented on an interagency basis using an interdisciplinary approach in which providers have access to flexible, not-categorical funding. Wraparound services must be delivered on an unconditional basis where the nature of support changes to meet changes in families and their situations. Finally, wraparound involved the measurement of child and family outcomes to determine the effectiveness of services that ensure that appropriate populations are being served.

The proposed wraparound services are divided out into two separate categories of service: Wraparound services, licensed skilled professional; and Wraparound services unskilled. The list below, while not an exhaustive list, is a list of the services expected to be provided to participants by wraparound providers as well as the level of skill DOM requires for the service delivered. The list provides for categories and sublistings of service types.

Mental Health Services

1. Intensive, In-home therapy is a skilled service provided by an individual with a Master's degree.
2. Day Treatment is a skilled service provided by an organization that provides a leader with a Master's degree and an unskilled aid for every nine (9) youth.
3. Crisis Outreach is a skilled service provided by an organization that provides for staff with a Bachelor's degree.
4. Group Therapy is a skilled service provided by an individual with a Master's degree for up to 8 youth per session.
5. Family Therapy is a skilled service provided by an individual with a Master's degree.
6. Substance Abuse Treatment is a skilled service provided by an organization that provides that services are the responsibility of a staff with a Master's degree.
7. Community-Based Respite (non-clinical) is an unskilled service provided by an organization that provides individuals with a high-school diploma or equivalent to directly provide the services.
8. Psychiatric Services are skilled services provided by an individual who is a psychiatrist (MD) or psychiatric mental health nurse practitioner (NP).
9. Aide services are unskilled services provided by an individual with a high school diploma or equivalent and one year experience.

Social Services

1. Basic Needs are skilled services provided by an individual with a Bachelor's degree.
2. Family Support is an unskilled service provided by an organization. The individual providing the service must have the appropriate level of training and experience.
3. Personal Skills Development could be skilled or unskilled services provided by an individual with a high school diploma, a Bachelor's or Master's Degree and relevant training and experience.
4. Mentoring is an unskilled service provided by an individual with relevant training.

Educational Services

1. Tutoring is an unskilled service provided by an individual with proficiency at the tutorial level and in the appropriate subject matter.
2. IDEA: IEP Development is an unskilled service provided by an organization. The individual providing the service must have the appropriate level of training and experience.
3. In-school Support is an unskilled service provided by an organization. The individual providing the service must have the appropriate level of training and experience.

Vocational Services

1. Prevocational Services is an unskilled service administered by an organization. The individual providing the service must hold a Bachelor’s degree and have the appropriate training.
2. Supported Employment is a skilled service administered by an organization. The individual providing the service must hold a Bachelor’s degree and have the appropriate training.

Recreational Services

1. Physical Fitness is an unskilled service administered by an organization. The individual providing the service must have the appropriate level of experience and proficiency.
2. Art and Music Therapy is a skilled service provided by an individual with the appropriate level of experience, proficiency and certification (if applicable).

Other Services

1. Transportation is an unskilled service administered by an organization. The individual providing the service must have a valid driver’s license and a safe vehicle.
2. Transitional Living is a skilled service administered by an organization. The individual providing the service must hold a Bachelor’s degree and have the appropriate training.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

One service per day equal to the number of certified days in the waiver.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	MH Waiver provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Wraparound

Provider Category:

Agency

Provider Type:

MH Waiver provider

Provider Qualifications

License (specify):

Certificate (specify):

Certified by DMH as case management provider.
Accredited program.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

ACS- DOMs fiscal agent
Division of Medicaid Mental Health Programs

Frequency of Verification:

Upon initial application. Provider is required to provide updated certification or accreditation prior to the expiration date of the previous certification/accreditation.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:
 - As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
 - As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
 - As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
 - As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All direct service staff employed by waiver providers are subject to criminal background checks.

Department of Public Safety Criminal Information Center (CIC) was established in accordance with Miss.Code Ann. '45-27-5. The CIC is responsible for the communication of vital information relating to crimes, criminals, and criminal activity. It is the state's criminal records repository and provides fingerprint-based identification services to law enforcement and other criminal justice entities in the State of Mississippi and throughout the United States. The individual will be fingerprinted by a fingerprint examiner from the Center's AFIS Division or other certified law enforcement personnel. Fingerprinting is required to ensure the record's security, to verify the identities of those who seek to inspect them, to ensure a person's right to privacy, and to maintain an orderly and efficient mechanism for such access.

The fingerprint image will be checked against the state database and submitted to the Federal Bureau of Investigation for a review of the federal records' database. When the results of the fingerprint checks are received, the Special Processing staff will contact the individuals employer to schedule a time for review of the record, if any record exists. This record will not be made available to a third party by the Center. An employer cautioned that any information located may not be conclusive or reflect ALL criminal history information on an individual, since the Center's database contains only criminal history information from March of 1998 to present and is dependant on submissions from state criminal justice agencies, prosecutors and court clerks. All inquiries concerning federal records will be directed to the Federal Bureau of Investigation. The Center may prescribe reasonable hours of inspections and may impose additional procedures, fees or restrictions as may be necessary.

The providers of the Waiver services are certified by the Department of Mental Health using the DMH Minimum Standards for Mental Health/Mental Retardation Services. As a requirement in meeting the Minimum Standards, Part II Organization and Management, Section B Personnel Policies, "the provider must document for all staff and volunteers that a criminal records background check (including prior convictions under the Vulnerable Adults Act) and child abuse registry check has been obtained and no information received that would exclude the employee/volunteer. The Department of Human Services (DHS) Division of Families and Children is responsible for maintaining the child abuse registry for the State of Mississippi. Additionally, each employee/volunteer hired after the effective date of these standards (July 1, 2002) must be fingerprinted." The Department of Mental Health, Division of Children & Youth Services' staff monitors the providers every six months or more often when necessary. The monitoring staff of the Division of Children & Youth Services will provide the Division of Medicaid with a report indicating any individual or agency that does not pass the criminal background investigation and/or the abuse registry background investigations. The Division of Children & Youth will provide a report prior to service delivery of the waiver services and every three to six months thereafter.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Department of Human Services (DHS) requires the screening of all persons in direct service positions. The Mississippi Department of Human Services does all of its background checks through the Mississippi Department Of Public Safety Criminal Information Center (CIC) under the Child Residential Agencies state law code '43-15-6. The central registry is an official repository for substantiated reports of abuse and neglect. The maintenance of a legally mandated by the Mississippi Youth Court Act and the Mississippi Vulnerable Adults Act. Names of individuals against names in the central registry to identify any substantiated perpetrators of abuse. It takes approximately 7-10 working days to return a Central Registry Check back. The information needed to complete the Central Registry Background Check includes the individual's full name (including maiden name and/or alias if applicable), social security number, birth date. The individual must sign a form authorizing permission for the check to be completed. A witness must sign his or her name verifying the individual's signature. Social workers can request Central Registry background checks on individuals whose

cases they are working. Child care facilities, schools, residential facilities, and DHS can request central registry checks on potential employees and volunteers. However, these agencies are required to have the appropriate signed permission from the individuals prior to submitting the request. The names of individuals determined to be "Substantiated Perpetrators" of child abuse and/or neglect remain on the Registry forever, unless the name is removed via the process of an Administrative Fair Hearing.

The providers of the Waiver services are certified by the Department of Mental Health using the DMH Minimum Standards for Mental Health/Mental Retardation Services. As a requirement in meeting the Minimum Standards, Part II Organization and Management, Section B Personnel Policies, "the provider must document for all staff and volunteers that a criminal records background check (including prior convictions under the Vulnerable Adults Act) and child abuse registry check has been obtained and no information received that would exclude the employee/volunteer. The Department of Human Services (DHS) Division of Families and Children is responsible for maintaining the child abuse registry for the State of Mississippi. Additionally, each employee/volunteer hired after the effective date of these standards (July 1, 2002) must be fingerprinted." The Department of Mental Health, Division of Children & Youth Services' staff monitors the providers every six months or more often when necessary. The monitoring staff of the Division of Children & Youth Services will provide the Division of Medicaid with a report indicating any individual or agency that does not pass the criminal background investigation and/or the abuse registry background investigations. The Division of Children & Youth will provide a report prior to service delivery of the waiver services and every three to six months thereafter.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The DOM selected providers through a competitive procurement process. The purpose of the procurement is to solicit proposals from qualified contractors wishing to provide services. The RFP is issued under the authority of Title XIX of the Social Security Act as amended, implementing regulations issued under the authority thereof and under the provisions of the Mississippi Code of 1972 as amended. In order to attract qualified providers and ensure the need for providers is advertised, a Request for Proposals (RFP) will be released and a public notice will be publicized once a week for two consecutive weeks in various news publications throughout the State.

DOM has chosen to use a selection methodology that incorporates the Mississippi personal services contract procurement procedures for competitive sealed proposals. These procedures are based on reasonable competition, standardized criteria and objective evaluation of submitted proposals and are administered by the DOM Procurement Officer. Submitted proposals will be evaluated based on the requirements outlined in Section 3.0, Project Description, of the RFP. The evaluation process consists of the appointment of an evaluation committee and completion of the evaluation form.

The evaluation form is the assessment tool that will be used by the evaluation committee to evaluate each submitted proposal, see attached. The criteria used to evaluate each provider are outlined in Section 6.0, Proposal Evaluation Criteria, of the RFP. The evaluation committee will review the provider's response to each requirement in order to determine if the provider sufficiently addresses the requirement and that the provider has developed a specific approach to meeting each requirement.

A point system will be used to rate each of the proposals. The Maximum number of points that may be received by each provider is outlined below:

Maximum Points Per Requirement

- 1. Statement of Understanding 20
- 2. Approach 50
- 3. Organizational Profile 20
- 4. Financial Information 10

Total Points 100

Upon completion of the evaluation, providers will be ranked based on the number of points received during the evaluation.

All proposals that meet the qualifications for submission will be reviewed in accordance with the system identified above. Those proposal in which the approach is consistent with the intent and design of the waiver program and whose proposed cost are within the DOM budget neutrality projection will ranked by the DOM review committee. Depending on the number and quality of proposals, DOM will select, at a minimum, two proposals. In order to quantify quality for the purpose of provider enrollment, a minimum threshold score of 80/100 has been established. Any provider who meets the threshold or 80 will be enrolled as a provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. **Methods for Discovery: Qualified Providers**
 - i. **Sub-Assurances:**

- a. **Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All (100%)waiver providers must meet the Medicaid provider qualifications to be enrolled. DOM verifies annually providers meet required licensing and/or certification standards and adhere to other State standards.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS and review of licensure/certification documents submitted.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All providers must receive adequate training and supervision, defined as orientation and supervised on the job training before being assigned independent responsibilities, 20 hrs of in-service training per year, training in professionally recognized method of handling difficult situations, de-escalating problem behaviors and crisis management and a min. of 4 hrs of clinical supervision per month.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DOM waiver staff will review the records to assess the Waiver Provider compliance with both state and federal requirements for mental health treatment and to monitor the quality of service being provided to the participant. DOM waiver staff will use the On- Site Compliance Review Process (OSCR) to conduct all reviews. Written notification of an OSCR will be provided to the Waiver Provider 24 – 48 hours prior to the time the OSCR is scheduled to begin. Once the Waiver Provider receives the pre-review notification there will be contact made with DOM to verify awareness of the upcoming OSCR.

The OSCR process is intended to monitor a Waiver Provider overall operation for compliance with legal requirements and for quality of clinical programs and services. The review inquires into three domains of the Waiver Provider operations. The three domains are Administration, Program, and Services. Each Waiver Provider will be scheduled for an OSCR every 90 days the first quarters of operation and at least annually. Interim reviews will be scheduled with the Waiver Provider when the provider is being reviewed for compliance with a corrective action plan (CAP). The OSCR will be completed in two (2) days in most cases.

Appeals Process

If the Waiver Provider disagrees with its status ruling or has a complaint regarding DOM’s response to its proposed CAP, it should address its concerns by following appeal process and address its concerns to:

Director, Division Special Mental Health Initiatives
 Bureau of Mental Health Programs
 Division of Medicaid

If the Waiver Provider disagrees with the response to its appeal, it should address its concerns to the:

Director, Bureau of Mental Health Programs
 Division of Medicaid

If the Waiver Provider disagrees with the results of this appeal, it should address its concerns to the:

Deputy Administrator, Health Services
 Division of Medicaid

If the Waiver Provider disagrees with the results of this appeal, it should address its concerns to the:

Executive Director
 Division of Medicaid

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Remediation Activity

When an issue arises in the Waiver Provider OSCR Review the Waiver Provider has the authority to respond appropriately and assure that corrective action is taken. DOM will track information on whether provider standards and assurances have been met during each review. Any Waiver Provider receiving a Review, Probation or Suspension must submit a Corrective Action Plan (CAP). The CAP must be received by DOM no later than 10 working days following the Waiver Provider receipt of its status ruling.

The CAP must address separately each concern cited in the OSCR report by:

- Proposing specific actions that will be taken to correct each identified problem,
- Specifying and implementation date for each corrective action
- Including supporting documentation as appropriate, e.g. policy or procedural changes, new or revised forms, copies of schedules of training or staffing, etc.

The CAP will include the name and telephone number of a Waiver staff member who will work with DOM towards approval of the CAP.

The DOM must approve/disapprove of the Waiver Provider proposed CAP within 10 working days of its receipt by DOM. The 10-day submission/10-day response cycle will continue until DOM approves a CAP. The Waiver Provider must implement the CAP within 30 days of its approval. When notifying the Waiver Provider of its CAP approval, DOM will also inform the Waiver Provider of the anticipated time of the next follow-up OSCR.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input data-bbox="878 422 1334 501" type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individualized Service Plan (ISP)

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker.**

Specify qualifications:

licensed certified social worker (clinical social worker) or licensed master social worker.

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The Wraparound Team develops the ISP/POC for the child/youth. The ISP/POC is developed based upon the Strengths and Needs Assessment and identified goals as determined by the team with family and consumer having primary role of identifying appropriate goals, strengths and needs. Input of all members of the team, with special consideration given to the family's and participant's wishes, is used to identify the appropriate services and natural supports that are built into the ISP/POC to move the participant towards meeting their goals. The PSC, as the wraparound facilitator, plays a role in this process by facilitating the ISP/POC development through documentation of the decisions made by the Wraparound Team, facilitating the overall meeting and assuring that all members of the team have the opportunity to participate. Access to services have not been infringed by are based on medical necessity as determined by the Wraparound team.

The participant/family has the ability to request a meeting of their Wraparound Team at any time they feel it is warranted should needs or circumstances change. A Family Support Specialist, a contract employee of DOM, will be available to participants and their families to attend wraparound team meetings if requested.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The MYPC Waiver Flyer that will be given to the Waiver Providers for dissemination to families states: "Family and Participant Choice is a key element in the waiver process". Keeping in mind that until the child/youth reaches the age of maturity, the parent(s) is considered the primary responsible person(s). The Waiver Provider will provide information about services and supports available and how the waiver can benefit the participant and family. An ISP/POC will be developed using the Wraparound Process. The participant/family will play a key role in choosing the members of their wraparound team due to this being a participant/family driven approach in the treatment process. Mississippi will utilize the strengths model which views the participant/family as the one who knows what they "need" versus the professionals being in charge. Participant/family is a necessary key component to whether treatment will be successful or not. The participant/family will have a Family Support Specialist to assist them in all avenues of the waiver program. Family Support Specialist will encourage and counsels the participant and their family members. The wraparound facilitator will lead the meetings and assist the team (which includes the participant/family) identify strengths and needs of the participant/ family. The participant/family ISP/POC will include and describe services, necessary activities, and training the participant/family has identified in the wraparound process. The waiver ISP/POC must be monitored at least every 90 days and/or any other time as needed. Families and participants are expected to be involved in the treatment planning and monitoring process. The required training provided to Wraparound Facilitators highlights the importance in the Wraparound meeting where the ISP/POC is developed actively reinforces that the process is family driven and that the ultimate decision for who participates, what goals are identified and what supports are accessed lies with the family/caretaker/parents.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The service plan development is the following process:

- (a) DOM will require the ISP be in place within 14 days of enrollment into the MYPAC waiver. The Wrap Meeting is scheduled at the earliest convenience to the family. During the Wraparound meeting, the ISP/POC is developed

that incorporates both formalized and natural supports to address the identified goals of the ISP/POC.

(b) A Strengths and Needs Assessment (SNA) is conducted as a part of the Wraparound process. Input into the Strengths and Needs Assessment is given by all participants including the family. The domains that are addressed in the SNA are: Home, Community, Financial/Economic, Health, Legal, Leisure/Recreation, Vocational/Educational, Socialization and Other. Goal development is directly related to the SNA. Goals are established based upon the Needs and interventions for goals are built upon the Strengths identified.

(c) Consumers and their family/parents/caretakers are informed at the time in which the Waiver is being considered of the array of services that may be accessed through the SED Waiver. The array of services available to the family includes the Waiver specific services, but they also include services available outside the Waiver. Natural occurring supports outside of the community mental health system are also utilized to support the family and formalized services are not incorporated to take the place of existing or identified natural supports.

(d) The Wraparound team identifies goals and interventions based upon the Strengths and Needs Assessment. Preference to the goals that are included in the ISP/POC is given to those the family/caretaker/parents and consumer may identify as the most pertinent or pressing.

(e) The core values of Community Based Services are Strengths-based, Family Centered, Culturally Respectful and Community Based. Wrap Around Process is a Family Centered process in which the family directs the membership of their team. Membership is reflective of persons the family has identified as a source of support, persons in the community that may be able to provide support in the future through natural supports and providers of service.

All services are coordinated first through the Wraparound team's development of the ISP/POC. It is the responsibility of the Wraparound team to develop the ISP/POC, the WA Facilitator guides that process including facilitating the larger gathering of all members that the family identifies (the wrap-around team) and making sure that the waiver "rules" are followed. The PSC is responsible for assuring needed resources are put in place for the family. Continuous monitoring of the plan occurs through 30 Day and Annual Reviews of the progress toward goals.

(f) The process for the on-going monitoring of the provision of services is identified in section D-2a.

(g) Required components of the ISP/POC include identifying the assigned task and person responsible for implementing each component/identified support/goal of the ISP/POC. This would include community partners that are identified by the Wrap Around to provide natural supports for the family to meet needs from the Strengths and Needs Assessment.

(h) Each ISP/POC has an identified Crisis Plan which identifies potential crisis, what action steps (strategies) need to be implemented and the person(s) responsible to mitigate the risk. See D-1e for further details.

(i) The ISP is updated at a minimum on an annual basis through the Wrap Around process. However, a Wrap Around meeting can be convened at any time in which needs or circumstances have changed or the family feels it is warranted, or the needs of the consumer require the team meet on a more frequent basis to best coordinate care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Each ISP/POC is required to contain a Individualized Crisis Management Plan (ICMP). The purpose of the ICMP is to identify on an individualized basis triggers which may lead to potential crisis and interventions that may be implemented to avoid the crisis altogether. ICMPs are developed in concert with the ISP/POC development during the Wraparound meeting based on the individualized preferences of the family/consumer. As with the ISP/POC itself, the family/consumer may choose to revise the ICMP at any time they feel it is necessary. Each ICMP is individualized to the youth and what a potential crisis (risk) and appropriate interventions (strategies to mitigate risk) may look like for them. Training provided to the PSC, who serves as the wraparound facilitator, highlights the need to identify different levels of intervention on an ICMP, the different stages of crisis and how a crisis may be defined differently by each family. All wraparound providers are required through the Medicaid provider agreement and the

RFP submission to provide ICMP response that is readily accessible to the youth and their families. A required component of the ICMP is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the ICMP as an attachment to their ISP/POC and have access to this information should a crisis occur. ICMP also may include natural supports as identified by the family and wraparound team as appropriate for a level of intervention during the planning process for crisis avoidance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

MS DOM solicited proposals from any willing and qualified provider of the services described in the waiver application. Those determined to meet the qualification as PSC and wraparound providers were enrolled as waiver providers. Youth enrolled in the waiver will have free choice of providers who are enrolled as MYPAC waiver providers and may change providers as often as desired. Enrollees will be given the choice of at least two providers. The informed choice will occur in at least 2 steps: First the potential applicant will be informed by the family support specialist (prior to enrollment in the waiver) of the availability of PRTF and waiver services. Next, if the guardian chooses the waiver, the FSS will provide information about the available waiver providers. The family will then make the final choice from the enrolled waiver providers. In the absence of a choice by the family, the applicant will be assigned to a waiver provider in their area. If the family does not exercise their right to choose, they will be randomly assigned to the available waiver providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Because the service plan is developed as a result of assessments completed in the first 14 days of program participation, a detailed plan cannot be submitted at the time of the initial certification by the QIO who will be determining medical necessity for level of care. However, waiver providers will be required to submit the ISP to the QIO within 30 days of entry into the waiver. DOM has access to all data on cases reviewed by the QIO.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):
- Medicaid agency
- Operating agency

Case manager

Other

Specify:

HealthSystems of Mississippi

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Division of Medicaid, specifically, the DOM MYPAC (waiver) staff, will be responsible for monitoring the implementation of the service plan and participant health and welfare. The Division will use OSCR (On-Site Compliance Review Process) to monitor the waiver program. The goal of OSCR is to assess the program and services offered by the Waiver Provider through direct observation, document review and staff to youth/family interviews by experienced professionals, and to provide clear, specific feedback regarding review findings to the waiver staff in order that services may be enhanced.

DOM's monitoring will include the following:

- a. Participant access to waiver services identified in the service plan
- b. Participants exercising free choice of providers
- c. Services meeting participants' needs
- d. Effectiveness of back-up plans
- e. Participants' health & welfare
- f. Participants' access to non-waiver services in services plans including health services
- g. Methods for prompt follow-up & remediation of identified problems.

As issues are identified in the monitoring processes, the Division will follow the Quality Management Strategy (identified in appendix H), whereby the waiver provider develops a plan for remediation and corrective action if necessary which must be submitted and approved by the DOM.

The monitoring and follow-up method(s) used are:

- 1) The PSC (case manager), an employee of the Waiver Provider, is responsible for and ensures that services are furnished in accordance with the ISP/POC as identified by the Wraparound team by:
 - a. implementing the ISP/POC
 - b. securing services authorized on the ISP/POC
 - c. monitoring the ISP/POC through face to face visits with consumer/family

The Waiver Provider is required to monitor all ISP/POC every 90 days (if not sooner) with the consumer and family and at a minimum every 12 months with the full wrap-around team.

- 2) The Division waiver staff will randomly monitor the ISP/POC for errors and excessive or inappropriate usage of community services. The DOM will select 10% of each waiver providers case load for the ISP monitoring. When an ISP/POC has been identified as having an error, is excessive or inappropriate, the DOM Special Mental Health Initiatives Director, who is responsible for the MYPAC waiver, will contact the waiver provider to inform them that the ISP/POC is in question. The service selection and usage must be justified or otherwise modified and resolved before approval and continuation of the ISP/POC is granted. The participant/family is notified and involved in the monitoring process.

- 3) Chart and Performance Improvement monitoring are completed on a quarterly basis.

Chart monitoring includes:

- a. Reviews the initial clinical eligibility packet to ensure the child's scores from the CANS assessment scale meet the SED criteria.
- b. Reviews the family choice assurance document, (family choice form)
- c. Notice of Action (which also explains the right to appeal)
- d. Comparing the ISP/POC to the actual services being delivered
- e. Reviews wrap around meeting progress notes, and list of team members to

- ensure the consumer/family is involved in the wraparound process
- f. Review of documentation ensuring that the consumer/family domain/needs strengths has been identified in the ISP/POC and are being meet.
 - g. Reviews documentation ensuring that appropriate goals and objectives has been identified in the ISP/POC
 - h. Review crisis plan ensuring that it addresses potential crisis situations, triggers, and precursors identified, action steps (strategies) for averting the crisis, crisis resolution, and crisis debriefing and identified the responsible person(s) to mitigate the risk.
 - i. Review budget to ensure it address the total cost for waiver and non-waiver services, crisis services, and beginning and end date of services.
 - j. Review signatures and dates to ensure that consumer (if age appropriate) / family, case manager, physician, and others have signed and dated the ISP/POC.

Chart reviews are completed by DOM waiver staff.

Problems identified through the quarterly chart reviews are reviewed by DOM Waiver Director, and QIO staff to determine compliance with Waiver rules and regulations.

4) Waiver providers will be monitored annually by the Department of Mental Health, as well as other state agencies, for continued licensing and certification. These reviews will be submitted to DOM, and in addition to any complaints from consumers or stakeholders, will be documented in the DOM reports to CMS.

5) The Division of Medicaid Program Integrity Bureau will have the responsibility of maintaining a fraud and abuse prevention and detection system. This system will “audit” HCBS SED waiver providers randomly to ensure integrity of the program. Additionally, this system will audit waiver providers based on identified system “triggers” and/or if recommended by the DOM Waiver Director on an as needed basis.

6) Each waiver provider reports to DOM’s automated information management system (MMIS) upon intake and monthly. Information collected contains extensive fields for tracking data such as demographics, services provided, custody status, residential placement, law enforcement Contact, academic performance, school attendance, etc. Reports are compiled on a quarterly basis by the State and reviewed for compliance with contractual outcomes.

7) Consumers and the families of youth consumers receiving HCBS SED Waiver services are Requested annually to participate in the Youth Satisfaction Survey and the Family Satisfaction Survey. Information collected contains consumer and family satisfaction with services provided, access to services, satisfaction with providers, access to crisis services, etc. Results of the Consumer and Family Satisfaction Surveys are reviewed for compliance with contractual outcomes.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The safeguards are listed above and include concurrent review and quality reviews by HSM, and on-site compliance reviews by DOM staff.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances
i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All (100%) participants will have in place an ISP/POC within 14 days of enrollment. The ISP/POC will include strategies for addressing the participants needs in 100% of the cases.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
DOM will monitor waiver providers in accordance with Medicaid policy section 17.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		95% +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All (100%)waiver participants must have an updated ISP/POC submitted annually for re-certification.

Data Source (Select one):

Other

If 'Other' is selected, specify:

UMQIO requires updated ISP/POC in order to complete re-certification.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: UMQIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The ISP/POC and related progress notes will be reviewed during the On-Site Compliance Review (OSCR) process to verify.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5% margin of error
<input type="checkbox"/> Other		

Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The freedom of choice form, which documents the families choice between institutional and HCBS services and the available providers is required for precertification for HCBS services by the UMQIO.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Required by precertification by the UMQIO. No one can be admitted to the HCBS waiver without one. DOM is responsible for contract monitoring of the UMQIO and can request evidence at any time.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: UMQIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Other Specify: UMQIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The OSCR process is intended to monitor a Waiver Provider overall operation for compliance with legal requirements and for quality of clinical programs and services. The review inquires into three domains of the Waiver Provider operations. The three domains are Administration, Program, and Services. Each Waiver Provider will be scheduled for an OSCR at least annually. Interim reviews will be scheduled with the Waiver Provider when the provider is being reviewed for compliance with a corrective action plan (CAP). The OSCR will be completed in two (2) days in most cases.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When an issue arises in the Waiver Provider OSCR Review the Waiver Provider has the authority to respond appropriately and assure that corrective action is taken. DOM will track information on whether provider standards and assurances have been met during each review. Any Waiver Provider receiving a Review, Probation or Suspension must submit a Corrective Action Plan (CAP). The CAP must be received by DOM no later than 10 working days following the Waiver Provider receipt of its status ruling.

The CAP must address separately each concern cited in the OSCR report by:

- Proposing specific actions that will be taken to correct each identified problem,
- Specifying and implementation date for each corrective action
- Including supporting documentation as appropriate, e.g. policy or procedural changes, new or revised forms, copies of schedules of training or staffing, etc.

The CAP will include the name and telephone number of a Waiver staff member who will work with DOM towards approval of the CAP.

The DOM must approve/disapprove of the Waiver Provider proposed CAP within 10 working days of its receipt by DOM. The 10-day submission/10-day response cycle will continue until DOM approves a CAP. The Waiver Provider must implement the CAP within 30 days of its approval. When notifying the Waiver Provider of its CAP approval, DOM will also inform the Waiver Provider of the anticipated time of the next follow-up OSCR.

Appeals Process

If the Waiver Provider disagrees with its status ruling or has a complaint regarding DOM’s response to its proposed CAP, it should address its concerns by following appeal process and address its concerns to:

Director, Division Special Mental Health Initiatives
 Bureau of Mental Health Programs
 Division of Medicaid

If the Waiver Provider disagrees with the response to its appeal, it should address its concerns to the:

Director, Bureau of Mental Health Programs
Division of Medicaid

If the Waiver Provider disagrees with the results of this appeal, it should address its concerns to the:

Deputy Administrator, Health Services
Division of Medicaid

If the Waiver Provider disagrees with the results of this appeal, it should address its concerns to the:

Executive Director
Division of Medicaid

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

A Fair hearing process/procedure may be requested or initiated in all instances when (a) individuals are not provided the choice of community-based services as an alternative to institutional care, (b) when individuals are denied the services of the their choice or the provider of their choice, or (c) individuals' services are denied, suspended, reduced, or terminated.

DOM will operate a grievance procedure (distinct from the fair hearing process) that provides for prompt resolution of issues not relating to appeals. These grievance procedures may not interfere with an enrollee's freedom to make a request for a fair hearing or an enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services or a denial or limitation of a service authorization.

The Waiver Provider shall report to DOM all grievances by consumers and/or family members of consumers, or third-parties on behalf of consumers and shall refer all appeals or fair hearing requests to DOM. DOM has the discretion to require the Waiver Provider to participate in any review, appeal, fair hearing or litigation involving issues related to this Waiver.

The Waiver Provider shall also establish a grievance system including written policies and procedures that meet the following requirements:

- a. Provides consumers reasonable assistance in completing forms and other procedural steps, not limited to providing interpreter services and toll free numbers and interpreter capability;
- b. Acknowledges receipt of each grievance and appeal received by the provider;
- c. Ensures that appeals addressing terminations, suspensions, and reductions of services or denials or limitations of authorizations are appropriately identified and forwarded to the Fair Hearing process when received by any employee or subcontractor of the Waiver Provider. This requirement does not relieve the provider from trying to informally resolve the enrollees appeal to the satisfaction of the enrollee prior to a formal Fair Hearing. However, any actions of the provider or any of its subcontractors may not create a barrier to accessing the Fair Hearing system for enrollees or impede due process in any way.
- d. Provides the following information on grievance and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a subcontract:
 - the consumer's right to a Fair Hearing, how to obtain a hearing, and right to representation at a hearing;
 - the right to file grievances and their requirements and timeframes for filing;
 - the availability of assistance in filing;
 - the toll-free numbers to file oral grievances;
 - the right to request continuation of benefits (as defined in 42 C.F.R. 438.420(b)(1) during a Fair Hearing appeal; if the Waiver Provider's Action in a Fair Hearing is upheld, the consumer may be liable for the cost of any continued benefits;
 - Any DOM-determined provider appeal rights to challenge the failure of the organization to cover a service.

Notice of Action

The Waiver Provider shall provide appropriate and timely notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested or agreed upon.

Language and Format of Notice

The Notice shall be written in language easily understood and be available in alternative formats, and in a manner that takes into consideration those with special needs.

Contents of Notice of Action

- a. Description of the action the provider has taken or intends to take
- b. Explanation for the action
- c. Notification that the consumer has the right to file an appeal
- d. Procedures for filing an appeal
- e. Notification of consumer's right to request a Fair Hearing, and
- f. Notice that the consumer has the right to have benefits continued pending the resolution of the appeal.

Timeframes for Notice

The Waiver Provider shall give notice of at least ten (10) calendar days before the date of any action to terminate, suspend, or reduce services. In the event of fraud or abuse the notice may be reduced to five (5) days. The period of advance notice may be shortened to one (1) day in the event of the death of the consumer; written request by a consumer to terminate services; consumer's admission to an institution where he (she) is ineligible for further services; consumer's whereabouts are unknown and contact information is invalid; consumer moves out of the jurisdiction of the waiver; or consumer's physician prescribes a change in the level of care.

Fair Hearing Appeals Process

The appeal process shall incorporate the following provisions:

- a. Appeals should be filed within a reasonable timeframe, not to exceed thirty calendar days from the date on the Notice of Action;
- b. Appeals may be either orally or in writing; however, and oral request to appeal shall be followed by a written, signed, appeal;
- c. All appeals received by the Waiver Provider and any subcontractor are directly forwarded on to the DOM Fair Hearing process.
- d. The Provider shall continue the benefits/services to the consumer if the Fair Hearing process requirements are met.

If the Waiver Provider continues or reinstates the benefits/services while the appeal is pending, the benefits shall be continued until one of the following occurs:

- a. The appeal is withdrawn;
- b. Fair Hearing decision is made, or
- c. Authorization expires or authorization service limits are met.

Access to Fair Hearing Process

If the consumer/family wishes to appeal a decision or request a fair hearing, the consumer or family should submit a written, taped, or other alternative format, request for an appeal within 30 days of the notice of this action to:

- Deny services
- Reduce services
- Deny continued stay

Effectuation When Services Were Not Furnished

The Waiver Provider shall authorize or facilitate the provision of the disputed services promptly and expeditiously if the services were not furnished while the appeal was pending and the Fair Hearing officer reverses a decision to deny, limit, or delay services. The Provider is responsible for payment if DOM reverses the Provider on appeal.

Monitoring

The Waiver Provider must maintain records of all grievances received. In addition, the records must also include accounts of any appeals received by the Provider or its subcontractors. All Providers are required to track grievances and appeals and are required by statute to have their own grievance response and tracking. All appeals must be forwarded onto the Fair Hearing process.

On a quarterly basis, the Waiver Provider shall submit to DOM a Quarterly Grievance and Appeal Report summarizing each grievance (on-going or resolved) and each appeal forwarded during the quarter.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
 Yes. The State operates an additional dispute resolution process

a. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- No. This Appendix does not apply**
 Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

a. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

b. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
 No. This Appendix does not apply (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The MS Department of Human Services (DHS) is responsible for receiving reports of suspected child abuse or child neglect and determining whether a report warrants an investigation based on current policies. MS Code 43-21-353 states: (1) Any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, child care giver, minister, law enforcement officer, public or private school employee or any other person having reasonable cause to suspect that a child is a neglected child or an abused child, shall cause an oral report to be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing to the Department of Human Services, and immediately a referral shall be made by the Department of Human Services to the youth court intake unit, which unit shall promptly comply with Section 43-21-357. Where appropriate, the Department of Human Services shall additionally make a referral to the youth court prosecutor. Upon receiving a report that a child has been abused and that the abusive act would be a felony under state law, the Department of Human Services shall promptly notify the law enforcement agency in whose jurisdiction the abuse occurred and shall notify the district attorney's office within seventy-two (72) hours. The law enforcement agency shall investigate the reported abuse immediately and shall file a preliminary report with the district attorney's office within twenty-four (24) hours and shall file a final report with the district attorney's office within seventy-two (72) hours. Reports may be made by contacting the Child Abuse/Neglect Hotline at 1-800-222-8000. DHS also has responsibility for the Vulnerable Adults Act, under MS Code 43-47-7 and the reporting requirements and time frames are the same.

Failure to report suspected abuse or neglect to DHS could result the individual being punished by a fine not to exceed Five Thousand Dollars (\$5,000.00), or by imprisonment in jail not to exceed one (1) year, or both. Mississippi Code of 1972, Annotated Section 43-21-353(7).

The State of Mississippi has in place the necessary safeguards to protect the health and welfare of persons receiving services including adequate reporting standards for all licensed and non-licensed providers of services under this waiver. Waiver providers are required to track the reporting of serious incidents as part of their on-going performance improvement plan. Incidents the plan will review shall include the following, at a minimum:

- Life threatening injuries
- ANY resident injuries incurred in the course of seclusion/restraint (only for Out-of-Home Respite)
- Allegations of staff misconduct
- Allegations of sexual activity between waiver participants
- Allegations of abuse or neglect of a youth.

Waiver provider policies and procedures shall include the following requirements:

- (1) Staff members shall be afforded the opportunity to confidentially report any incident that a staff member believes is appropriate for review by the risk management program.
- (2) Each action that the center or any other provider with which the center has an affiliation agreement takes in response to any incident that comes to the attention of the performance improvement plan shall conform to all statutory requirements for reasonable reporting of suspected incidents of either child abuse or neglect. If the allegations are confirmed, the DOM Division Director will work with the waiver provider to develop a corrective action plan around preventing incidents of abuse, neglect, or exploitation in the future.

Incidents must be reported in writing by the waiver provider to the DOM within one working day of the occurrence. DOM accepts reports in writing via secure fax. During the period of this waiver, DOM may accept reports via secure web-based reporting. In addition, DOM has an agreement with the MS DHS to share information about waiver participants who may have had reports of abuse or neglect. On a regular basis, not less than every 30 days, DOM will match the list of waiver participants against the reports of abuse and neglect in the DHS MACWIS system, which tracks all such reports for the State. In addition, DHS will set up a flag in their system that will alert them when a report of abuse or neglect is filed that the child is in the MYPAC waiver. DHS will, in turn, notify DOM immediately. This will ensure that providers are reporting to DOM as they are required to and identify any omissions for resolution.

The DOM will track these reports in an Excel spreadsheet by provider in order to identify trends. In addition, DOM will employ a social worker to monitor the initial and final reports to ensure appropriate action was taken by the provider for that issue and changes were implemented, if necessary, to prevent such occurrence in the future. That social worker will be the liaison with the MS DHS. DOM will use the trend data to determine if additional training or policy clarification is needed which would be initiated by DOM, in order to ensure the health and welfare of individuals in the waiver, if systemic issues are identified.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Family Support Specialist will provide this information at the time the individual is entering services. The DOM will be responsible for developing informational materials. The Community Mental Health Centers will also provide updated information to the families when they conduct the assessments required for the National Evaluation every 6 months.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

As described in G-1-a, the Department of Human services has the statutory responsibility for investigations of child or adult abuse or neglect as defined in MS Code 43-21-355 and 43-47-7. On a regular basis, not less than every 30 days, DOM will match the list of waiver participants against the reports of abuse and neglect in the DHS MACWIS system, which tracks all such reports for the State. In addition, DHS will set up a flag in their system that will alert them when a report of abuse or neglect is filed that the youth is in the MYPAC waiver. DHS will, in turn, notify DOM immediately. This will ensure that providers are reporting to DOM as they are required to and identify any omissions for resolution. The DOM will track these reports in an Excel spreadsheet by provider in order to identify trends. DOM will employ a social worker to monitor the initial and final reports to ensure appropriate action was taken by the provider for that issue and changes were implemented, if necessary, to prevent such occurrence in the future. That social worker will be the liaison with the MS DHS. DOM will use the trend data to determine if additional training or policy clarification is needed which would be initiated by DOM, in order to ensure the health and welfare of individuals in the waiver, if systemic issues are identified.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The MS Department of Human Services (DHS) is responsible for investigating all reports. The DOM Division of Special Mental Health Initiatives is responsible for overseeing and obtaining all reports. Reports are collected by the State waiver staff from the DHS Child Protective Services including reports, investigations and findings. All are documented in a spreadsheet maintained by DOM Special Mental Health Initiatives Division which are aggregated and tracked to determine if trends are present. All reports directly from the waiver provider to the DOM are documented in an Excel spreadsheet which can be reviewed at any time to track trends. It will be reviewed at least quarterly by the DOM MH QI Team. If trends are present, the DOM waiver Director will notify the waiver provider that trends have been identified and the waiver provider will be required to submit a corrective action plan which outlines the waiver providers plan to prevent abuse, neglect and exploitation of waiver participants.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

- a. Use of Restraints or Seclusion.** (*Select one*):

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The Division of Medicaid will review policies of waiver providers, Medicaid policy will not allow the use of seclusion or restraint in a community setting for waiver participants and on-site compliance reviews will detect any unauthorized use.

- The use of restraints or seclusion is permitted during the course of the delivery of waiver services.**
Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

As previously mentioned, the Division of Medicaid will conduct on-site compliance reviews of all waiver providers. This is detailed in the Quality Management Strategy. The on-site compliance reviews will include review of records and interviews with parents and youth in the waiver. There will be specific questions on the tool to address the use of restrictive interventions. These reviews will be done at least annually, with the intent of every 3-6 months in the first year to assure new waiver providers fully understand the policy outlined for them by DOM.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

a. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

When the participant is served in a living arrangement where the Waiver Provider has round-the-clock responsibility for the health and welfare of participant, the State of Mississippi ensures that the participant medications are managed appropriately.

DOM waiver staff will conduct reviews every 90 days the first four quarters of the program operation and again once a year. This information will be documented in the Waiver Provider QA quarterly reports which will be aggregated and tracked to determine if trends are present. If trends are present, the DOM Waiver Division Director and staff will execute a corrective action plan with the Waiver Provider in question to correct identified deficits. The purpose of these reviews will be to identify practices that may be harmful to participants and will develop the appropriate corrective actions to address identified deficits. The Waiver Provider and any sub-contractor waiver provider will have the ongoing responsibility for the first line monitoring participant's medication regimens. Responsibility for medication management provided by the Waiver Provider includes:

- The medical responsibility for any participant to whom the licensee provides services shall be vested in a licensed physician. If the physician is not a psychiatrist, then a psychiatric consultant shall be made available to this physician and to other staff assigned to work with that consumer on a continuing and regularly scheduled basis.
- Each licensee shall provide its services using appropriately trained or professionally qualified staff. Each licensee shall ensure that it retains the services of sufficient staff to appropriately meet the needs of those participants to whom the licensee is providing any services.

All treatment shall be provided by, or provided under the direction or supervision of professionally qualified staff. Medication is reviewed by appropriately qualified staff. Appropriately qualified staff includes physicians, physician assistants, and advanced registered nurse practitioners acting within the scope of their professional licensure. Specifically, the treatment regimen including medication management be regularly reviewed and revised as appropriate, with the participation of the participant/parent/guardian and, when appropriate, one or more members of the family of that participant or other individuals designated by that participant.

Reviews and revisions shall occur at periodic intervals of not more than 90 days by the Waiver Provider and shall be updated with appropriate notations in the clinical record.

Medication management required of the waiver providers includes the following:

- A prescription for any medication required to treat the youth's mental illness (MI) or severe emotional disturbance (SED);
- Assistance with obtaining any medication prescribed for the treatment of the youth's MI or SED;
- Education concerning the effects, benefits and proper usage and storage of any medication prescribed for the treatment of the youth's MI or SED;
- Assistance with the administration of, or with monitoring the administration of any medication prescribed for the treatment of the youth's MI or SED;
- Any physiological testing or other evaluation necessary to monitor that consumer for adverse reactions to or

for other health-related issues that might arise in conjunction with, the taking of any medication prescribed for the treatment of the youth's MI or SED.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

When the participant is served in a living arrangement where the Waiver Provider has round-the-clock responsibility for the health and welfare of participant, the State of Mississippi ensures that the participant medications are managed appropriately through the following mechanisms:

- Be performed by adequately trained and professionally qualified staff.
- Be developed with the involvement of the participant/parent/guardian and, if appropriate, one or more members of the family of that participant or other individuals designated by the participant, evidenced by the signature of that participant or by other documentation indicating this participation and stating the reason for the absence of the participant's signature.

MS Division of Medicaid specifies that the treating physician shall perform any physiological testing or other evaluation necessary to monitor the participant for adverse actions to, or for other health-related issues that might arise in conjunction with, the taking of any medication prescribed for the treatment of the participant's mental illness or severe emotional disturbance.

All medication services must be correctly documented in the participants chart as specified in federal regulations.

The Waiver Provider and any sub- contractor waiver provider are required by regulation to maintain a Risk management Program, which details the method(s) for following up on potentially harmful practices. This includes follow-up and oversight of any act or omission that falls or might fall below the applicable standard of care or professional obligation. This requirement also specifies that each action that the center, affiliated center, or any other provider with which the waiver provider has an affiliation agreement takes in response to any incident that comes to the attention of the risk management program shall conform to all statutory requirements for reasonable reporting of suspected incidents of child abuse, neglect, or exploitation.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
Do not complete the rest of this section

- i. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All (100%) serious occurrence reports will be collected and reviewed by DOM on an ongoing basis.

Data Source (Select one):
Critical events and incident reports
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DOM MH will enter information on incident type, response time, and remediation into the Excel spreadsheet. When necessary, the Waiver director will take immediate and appropriate action to remediate situations when the health or welfare of a consumer has not been safeguarded.

As necessary, the waiver provider and DOM Staff will work together to develop and implement strategies for prevention. The Waiver Director will review the critical events spreadsheets with the social work monthly, at a minimum, to identify trends within the program as a whole and determine what changes the State should make in order to improve the system and thereby reduce the incidence of critical events.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

All issues related to waiver operation are continuously monitored at 100%. Provider feedback of systemic issues has and will continue to be an important part of systemic change.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Other Specify: Continuous and on-going

b. System Design Changes

- i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

When changes are implemented, the effective change date will be entered into our track and trend data from the On-site compliance review process to determine if systemic changes led to program improvement and that will be monitored annually at a minimum.

- ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Annually, DOM will evaluate the QIS and collect all information required by CMS to determine that evidence can be provided at any time on all elements. DOM will conduct an internal audit of our QIS.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Mississippi Division of Medicaid operates two audit units to assure provider integrity and proper payment for Medicaid services rendered. The Program Integrity Bureau investigates any suspicion of fraud or abuse reported or identified through the surveillance and utilization reporting (SURS) program. The Compliance and Financial Review Bureau conducts routine monitoring of cost reports and contracts with other agencies.

Payments will be monitored through monthly reports by the Bureau of Mental Health Programs. In addition, these waiver services like all Medicaid services are subject to investigation by Program Integrity. Generally, providers who fall outside the expected parameters for payments are subject to review. It is also possible to set up filters specifically for the waiver programs to identify areas of misuse.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

DOM will conduct financial audits of the waiver providers. The Division will generate financial reporting for each Waiver service provided. The audit will verify the maintenance of appropriate financial records and review claims to verify coding and accuracy of the payment made. DOM will review all audits bi-annually. Immediate action will be taken to address financial irregularities identified.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Claims monitoring through DSS to identify irregularities or MMIS failure.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

All (100%) waiver providers are reimbursed for services through the Medicaid MMIS claims processing system. When claim problems are identified DOM waiver staff conducts a full investigation on the claim in question. When claims resolution has been determined by DOM the provider is notified of the necessary steps to take for claims adjudication.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Division of Medicaid is responsible for setting rates for all providers that aren't specifically outlined in State law. For the waiver program, the Division of Medicaid consulted other state agencies who were providing services of a similar scope but to a different population. The rates DOM proposed in our grant application and our financial neutrality documents remain tentative. It is our intent to use that as a guide for the purposes of maintaining budget neutrality, but also to all the potential waiver providers who respond to the RFP to bid on their cost of services. We are hopeful that through this method, we will be able to get the most service for the dollar from the waiver providers. Final rates will be set by the RFP review committee after reviewing all proposals and comparing the proposed rates to those of other similar services.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims will be submitted by the waiver provider to the fiscal agent via the MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures *(select one):***

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Division of Medicaid will set up several edits on the front end to assure services are provided as they should be. In order for claims to pay for a specific beneficiary, they must be locked into this specific waiver for the dates of service. This will also prevent services that should be covered under "wrap around" by the waiver provider from being billed separately by other providers in the community. In addition to the overall lock-in, the services approved on the service plan will be entered into our prior authorization application of our MMIS, so the services will be checked against the PA file during the claims adjudication process. Verifying the services were provided will be done as a back end activity through our on-site compliance review process described in the Quality Management section.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability**I-3: Payment (6 of 7)**

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability**I-3: Payment (7 of 7)****g. Additional Payment Arrangements**

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

- Applicable**

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a.

Services Furnished in Residential Settings. *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

If a waiver participant is in a PRTF for short term respite, DOM pays the provider in the same manner it currently does for PRTF service at the per diem rate for that provider. However, there is a cost sharing model whereby the waiver provider pays the first 9 days, DOM the next 10 days and the provider the next 10 days, if applicable.

If services are provided in a group home setting, DOM is only paying for the cost of wraparound previously identified. There are no additional payments to the waiver provider to cover the cost of room and board in residential settings.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a.

Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care:

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	40767.00	2136.00	42903.00	58280.00	2136.00	60416.00	17513.00
2	28043.00	2229.00	30272.00	61194.00	2229.00	63423.00	33151.00
3	25730.00	2340.00	28070.00	64254.00	2340.00	66594.00	38524.00
4	26709.00	2457.00	29166.00	67467.00	2457.00	69924.00	40758.00
5	28165.00	2580.00	30745.00	70840.00	2580.00	73420.00	42675.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		PRTF	
Year 1	120	120	
Year 2	350	350	
Year 3	500	500	
Year 4	550	550	
Year 5	600	600	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Length of stay is estimated as approximately 6 months. The average length of stay in a PRTF is 6 months. Annual re-certification is due at 12 months. Based on the 372 report from Year 1, DOM has estimated the ALOS as 6 months. Based on the 372 report from Year 2, DOM has reduced the ALOS estimate for Yrs 3, 4 and 5.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Cost of service data from the C-TAC Planning Grant. Also considered in the estimate were the cost trends for PRTFs over the past 5 years. An inflation factor of 5% was originally added for each year beginning with Year 3. Because of state budget concerns, the rate for yr 3 and yr 4 remained constant. The inflation factor was added in Yr. 5.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Actual average cost per Medicaid beneficiary under age 21 for fiscal year 2006 pulled from paid claims data. In estimates for future years, a 5% increase in the cost was added for each year.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Current PRTF cost based on a 188 day length of stay. Data to support this were obtained through the C-TAC Planning Grant and the DOM Quality Improvement Organization. The data matched.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Current PRTF cost based on a 188 day length of stay. Data to support this were obtained through the C-TAC planning Grant and the DOM Quality Improvement Organization. The data matched. MMIS claims data from fiscal year 2006

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Case Management	
Respite	
Functional Assessment	
Wraparound	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						1512000.00
Case Management	Month	120	9.00	1400.00	1512000.00	
Respite Total:						80000.00
Respite	Day	20	10.00	400.00	80000.00	
Functional Assessment Total:						60000.00
Functional Assessment	Service	120	2.00	250.00	60000.00	
Wraparound Total:						3240000.00
Wraparound	Day	120	270.00	100.00	3240000.00	
GRAND TOTAL:						4892000.00
Total Estimated Unduplicated Participants:						120
Factor D (Divide total by number of participants):						40767.00
Average Length of Stay on the Waiver:						270

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						2940000.00
Case Management	Month	350	6.00	1400.00	2940000.00	
Respite Total:						400000.00
Respite	Day	100	10.00	400.00	400000.00	
Functional Assessment Total:						175000.00
Functional Assessment	Service	350	2.00	250.00	175000.00	
Wraparound Total:						6300000.00
Wraparound	Day	350	180.00	100.00	6300000.00	
GRAND TOTAL:						9815000.00
Total Estimated Unduplicated Participants:						350
Factor D (Divide total by number of participants):						28043.00
Average Length of Stay on the Waiver:						180

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						4200000.00
Case Management	Month	500	6.00	1400.00	4200000.00	
Respite Total:						440000.00
Respite	Day	110	10.00	400.00	440000.00	
Functional Assessment Total:						225000.00
Functional Assessment	Service	500	2.00	225.00	225000.00	
Wraparound Total:						8000000.00
Wraparound	Day	500	160.00	100.00	8000000.00	
GRAND TOTAL:						12865000.00
Total Estimated Unduplicated Participants:						500
Factor D (Divide total by number of participants):						25730.00
Average Length of Stay on the Waiver:						160

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						4620000.00
Case Management	Month	550	6.00	1400.00	4620000.00	
GRAND TOTAL:						14690000.00
Total Estimated Unduplicated Participants:						550
Factor D (Divide total by number of participants):						26709.00
Average Length of Stay on the Waiver:						170

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						500000.00
Respite	Day	125	10.00	400.00	500000.00	
Functional Assessment Total:						220000.00
Functional Assessment	Service	550	2.00	200.00	220000.00	
Wraparound Total:						9350000.00
Wraparound	Day	550	170.00	100.00	9350000.00	
GRAND TOTAL:						14690000.00
Total Estimated Unduplicated Participants:						550
Factor D (Divide total by number of participants):						26709.00
Average Length of Stay on the Waiver:						170

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						5292000.00
Case Management	Month	600	6.00	1470.00	5292000.00	
Respite Total:						567000.00
Respite	Day	135	10.00	420.00	567000.00	
Functional Assessment Total:						240000.00
Functional Assessment	Service	600	2.00	200.00	240000.00	
Wraparound Total:						10800000.00
Wraparound	Day	600	180.00	100.00	10800000.00	
GRAND TOTAL:						16899000.00
Total Estimated Unduplicated Participants:						600
Factor D (Divide total by number of participants):						28165.00
Average Length of Stay on the Waiver:						180